UTILIZATION REVIEW REPORT

INTRODUCTION

Under the provisions of the Multipurpose Senior Services Program's (MSSP) Home- and Community-Based Services (HCBS) Waiver and the State Medicaid Plan, the program is required to establish and maintain a system of Utilization Review (UR). The authority to conduct these reviews is found in the following sources:

Federal – Title XIX, Social Security Act, Section 1915 I; 42 Code of Federal Regulations (CFR), Section 456; Federal Home- and Community-Based Services Waiver.

State – Welfare and Institutions (W&I) Code, Section 14170; Title 22 California Code of Regulations, Title XXII, Section 51346; Interagency Agreement #01-15976 between Department of Health Care Services (DHCS) and California Department of Aging (CDA) and CDA policies.

The CDA conducts collaborative and independent URs to monitor the program at the site level for compliance with the Waiver, the Interagency Agreement (IA) between CDA and DHCS, and CDA MSSP policies. Currently, each site is scheduled to be reviewed every other year. The objectives of the CDA UR process are to:

1. Verify the medical necessity of services provided to eligible MSSP clients funded by the HCBS Waiver.

2. Ensure that available resources and services are being used efficiently and effectively.

3. Identify problem areas and to provide technical assistance (TA) as needed.

4. Initiate corrective action(s), if warranted.

The process followed by the CDA UR team involves a review of pertinent documentation, procedures and processes; consultation and discussion with staff; and a home visit to a client. The specific areas addressed by this report are:

1. NECESSITY OF SERVICES: Client Eligibility and Level of Care (LOC).

2. CLIENT ENROLLMENT, RIGHTS, AND INFORMATION: Application, Client Enrollment /Termination Information Form (CETIF), Notification of Rights, Authorization for Use and Disclosure of Protected Health Information Form (AUDPHI), Institutionalization Form (IF).

3. APPROPRIATENESS OF SERVICES: Initial Health Assessment (IHA), Initial Psychosocial Assessment, Reassessment (IPSA), Care Plan, Assessing and Documenting Client Risk, Progress Notes, and Case Record.

4. AUTHORIZATION AND UTILIZATION OF SERVICES: Service Planning and Utilization Summary (SPUS), Tracking Cost Effectiveness, and Vendor Agreement Review.

5. QUALITY ASSURANCE ACTIVITIES: Peer/Internal Review, Client Satisfaction Survey and Home Visit.

METHODOLOGY

Review Date:	March 15. 2010 through March 17, 2010
Review Site:	Multipurpose Senior Services Program-16 Senior Care Network Huntington Hospital 837 South Fair Oaks Avenue, Suite 100 Pasadena, California 91105-2619
Record Review:	Twenty records, including six closed cases
Review Period:	August 2008 through September 2009
CDA-MSSP Review Team:	Francie Posey, Nurse Evaluator II Susan Rodrigues, Program Analyst II Vicki Cabassi, Nurse Evaluator II Jennifer Luna Friedrich, Program Analyst II
Scheduled Conferences:	Entrance: March 15, 2010; Exit: March 17, 2010
Conference Participants:	Neena Bixby, Administrative Director Eileen Koons, Site Director Jim Passey, Compliance Officer Pat Trollman, Supervising Care Manager (SCM) Charleen Crean, SCM Alice Cortez, Nurse Care Manager (NCM) Ellen Blackstock, NCM Cecilia Duran, NCM Winnie Tam, Social Worker Care Manager (SWCM) Hermalinda Geronimo, SWCM Teresa Hernandez, SWCM Ruben Fierro, SWCM Robin Johnson, SWCM Shawn Azar, SWCM Angelina Garcia, SWCM (temp) Cathy Goyette, Fiscal Officer Maria Espinoza, Clerical Support Hanan Salim, Data Support

DEFINITION OF TERMS

1. Findings:
   - Conclusions reached after the UR. Documents site practices during the review period. Compares what exists at the site with what is required.

2. Recommendations:
   - Actions necessary to correct existing conditions or improve operations and practices. The recommendations indicated in this report are requirements not suggestions.

3. Technical Assistance:
   - Documents information provided to site staff during UR. Includes consultation on specific client cases, printed information, online resources, policy references, etc. TA may also document subsequent research and responses provided to site staff following the UR.

4. Corrective Action:
   - Remediates problems found in site practices and ensures compliance to MSSP policies including the federal Waiver and the current Contract. A Corrective Action Plan (CAP) includes but is not limited to the following:

     ➢ Revision of the site's existing procedures and practices or development of new ones. The site shall submit written documentation describing these changes.

     ➢ Training of site staff necessary to implement the required CAP. Training documentation to be submitted to CDA may include, but is not limited to, the following:
        - Schedule of in-service sessions and dates;
        - Sign-up sheet or roster of session attendees;
        - Agenda or syllabi of sessions (topics covered);
        - Name of person(s) conducting the sessions;
        - Session hand-outs; and
        - Synopses of session results including specific problem areas addressed.

     ➢ Periodic submittals to CDA, which may include examples of redacted case record documents, such as care plans, assessment forms, progress notes, etc., produced following the required training and remediation.

CORRECTIVE ACTION PLAN

A CAP is required as specified in the following UR Findings. A CAP is required to ensure compliance with the listed findings and recommendations. Please submit to CDA within 30 days. CDA reviewers may attend scheduled in-service training sessions developed in conjunction with the CAP without notice.

I. NECESSITY OF SERVICES

The objective of the MSSP is to avoid, delay, or remedy the inappropriate placement of persons in nursing facilities, while fostering independent living in the community. At a cost lower than nursing facility placement, MSSP provides services to eligible clients and their families to enable clients to remain in or return to their homes. Case record documentation must support the client's need for these services.

Reference: MSSP Site Manual

I. A. Client Eligibility

Eligibility for the program is addressed initially at screening and confirmed throughout participation in the program. MSSP eligibility criteria include all of the following:

- Age 65 or older;
- Residence in the catchment area;
- Receiving Medi-Cal under an appropriate code;
- Certifiable for placement in a nursing facility (refer to the LOC section of this report for criteria requirements);
- Ability to be served within the cost limitations of MSSP, and
- Appropriate for care management services.

Reference: MSSP Site Manual

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

I. B. Level of Care

The LOC determination is a clinical judgment made by the NCM. The LOC is a timely analysis of information gathered to determine and verify that the client is certifiable for placement in an Intermediate Care Facility (ICF) or Skilled Nursing Facility (SNF). The body of the client's case record must support the LOC determination.

References: California Code of Regulations, Title 22, and MSSP Site Manual

Findings:

Client Records #XXXX and #XXXX contained LOCs that did not address the clients' cognition.

Client Record # XXXX contained a LOC that did not address all ADL/IADLs nor the type of assistance the client needed to accomplish tasks.

Client Records #XXXX and #XXXX did not specify the type of assistance clients needed to accomplish tasks.

Recommendations:

Incorporate the following TA into policies and procedures.

Technical Assistance:

Refer to MSSP Site Manual Section 3.110.3, Appendices 19e, and 20b. The areas to address include:

- Cognition
- Ambulation, including use of assistive devices and need for human help
- Medication complexity, high risk medications (coumadin, insulin, digoxin,) compliance
- Ability to self-assess and report appropriately
- Need for nurse observation and oversight whether intermittent or more ongoing
- Need for assistance (cueing, stand-by, hands-on, total) with ADL and IADL management
- Health status, whether stable or fluctuating

If the client does not need assistance with all ADLs and IADLs, LOCs need to specify each impaired activity and the type of assistance each requires. For the bathing ADL, one client may need only a reminder to bathe while another client may need direct human assistance while bathing and would be at risk if left alone. For the eating ADL, a client may be able to feed him/herself, but may need reminders or encouragement to eat. A client needing this kind of verbal assistance is not considered independent for the activity.

Corrective Action:

The findings did not constitute trends; therefore, a CAP is not required.

II. CLIENT ENROLLMENT, RIGHTS AND INFORMATION

II. A. Application

The application form is the vehicle for applying for services and summarizes what a client can expect from MSSP, alternatives regarding services and the rights of program participants. The application must be completed prior to conducting the LOC determination, and a copy of the application must be provided to the client.

References: California Code of Regulations, Title 22, and MSSP Site Manual

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

II. B. Client Enrollment/Termination Information Form

The CETIF records client demographic information. Data fields must be complete and accurate. As data is changed or updated, a new hard copy must be printed and filed chronologically in the record.

References: MSSP Site Manual and MSSP Contract.

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

II. C. Notification of Rights

MSSP sites must inform clients and/or their designees of their right to be informed of MSSP components which are material to a client's participation (or lack of participation) in the MSSP. Program components include:

1. Processes on registering complaints, termination and appeal;

2. The safeguarding of client information (including application, Care Plan and termination form) through proper use of the Use and Disclosure of Protected Health Information Form and storage of client records;

3. Services that may be provided by MSSP as well as alternatives to participation in the program;

4. Potential outcomes of refusing offered services; and

5. Client participation in MSSP care planning and service satisfaction surveys.

Notices of Action (Termination and Change):

- State law and Medi-Cal regulations require that a Notice of Action (NOA) be sent to an applicant who is denied eligibility at point of application or to a MSSP client who has a change in service or who is terminated (for codes specified in the Site Manual) from the program. Timeframes for mailing NOAs are specified in the Site Manual. The NOA informs the applicant/client of rights to a fair hearing if they are dissatisfied with the termination action, change in services, or denial of entry into the MSSP. A copy of the NOA will be filed in the client's case record.

Client Rights/Right to State Hearing:

- Clients will be informed in writing and in a timely manner of their right to request a State Medi-Cal hearing when they indicate disagreement with any decision, which would result in a discontinuance, termination, suspension, cancellation or decrease of services under the program.

Reference: MSSP Site Manual and California Welfare and Institutions Code

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

II. D. Authorization for Use and Disclosure of Protected Health Information Form

MSSP sites must comply with contract requirements regarding client confidentiality. Sharing and obtaining information requires specific client consent as provided in the AUDPHI. This form must:

- Address only one individual or agency;
- Be specific as to the particular information (such as diagnosis, treatment, or financial information) that is requested from/to that entity; and
- Include an expiration date which cannot exceed two years from the date of the client's signature.

References: MSSP Site Manual and MSSP Contract

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

II. E. Institutionalization Form

Information regarding a client's admissions to a hospital (in-patient and out-patient) or nursing facility and emergency room visits are to be recorded on the IF. MSSP sites are responsible for the inclusion of the IF in the client case record. The IF provides a chronology of the client's hospitalizations and admitting diagnoses.

Reference: MSSP Site Manual

Findings:

Client Record #XXXX did not contain an entry on the IF regarding the client's XXXXXXXXX XXXX hospitalization.

Client Record #XXXX did not contain entries on the IF for the client's XXXXXXX XXXX and XXXXXXX XXXX emergency room visits.

Recommendations:

Incorporate the following TA into policies and procedures.

Technical Assistance:

Review MSSP Site Manual Section 3.1220 Institutionalization Form that states, "Information regarding a client's admissions to a hospital (in-patient and out-patient) or nursing facility and emergency room visits are to be recorded on the Institutionalization Form (Appendix 23)."

Corrective Action:

The findings did not constitute a trend; therefore, a CAP is not required.

III. APPROPRIATENESS OF SERVICES

The criteria for Appropriateness of Services address the client's need for and ability and willingness to participate in the care management process. Both elements must be present.

- "Need for care management" is indicated when a client requires assistance to: gain access to community services (whatever the funding source); maintain or effectively utilize available services; or manage serious health conditions.

- "Ability and willingness to participate" is indicated by the client's cooperation in formulating and then carrying out the Care Plan. The term "client" includes a client's significant support person when the client is cognitively unable to participate independently.

It is important to confirm and document a new client's perception of why they were referred to the program, and how they characterize their situation, needs and goals. This would logically occur during either the screening or the assessment process. Differences in perceptions between the referral source, the client and the care manager (CM) must be identified, acknowledged and addressed in the initial assessments.

References: MSSP Site Manual and MSSP Contract

III. A. Initial Health Assessment, Initial Psychosocial Assessment, and Reassessment

Assessment is the foundation of the care management process. Each person determined to be eligible through the MSSP intake screening process will receive face-to-face comprehensive initial health and psychosocial assessments to determine specific problems, resources, strengths, needs and preferences and to confirm LOC.

Reassessment is a formalized method of documenting and analyzing changes during the period since the previous assessment, re-establishing eligibility as it relates to LOC and assuring that the client's needs are being met. Changes since the last assessment, as well as over a longer span of time, are particularly relevant.

Assessment instruments and forms include but are not limited to:

- IHA and IPSA
- Reassessments
- Summaries and Problem Lists
- Client's Medication List
- Client's Physicians and Other Health Professionals
- Initial Psychosocial Functioning
- CDA-Approved Cognitive Evaluation
- Functional Needs Assessment Grid

References: MSSP Site Manual and MSSP Contract

Findings:

The IHA in Client Record #XXXX did not have an entry in the XXXX XXX section.

The IPSA in Client Record #XXXX did not contain information in the financial, environmental safety, and stair climbing sections.

The IHA/IPSA in Client Record #XXXX lacked entries in the client rating of own health, financial, and stair climbing sections. The reassessment equipment needs section contained "n/a" regarding handheld shower, emergency alarm unit, raised toilet seat and bedside commode.

Recommendations:

Incorporate the following TA into policies and procedures.

Technical Assistance:

Review MSSP Site Manual Section 3.620 Assessment/Initial Assessment that requires all areas of assessment and reassessment forms to be completed. When "n/a" is used, it is unclear whether the question was fully addressed. Many sites use "yes/no" responses for clarity.

Corrective Action:

The findings did not constitute trends; therefore, a CAP is not required.

III. B. Care Plan

Care planning is the process of developing an agreement between the client and CM regarding identified client problems and resources, outcomes to be achieved and services to be pursued in support of goal achievement. The Care Plan must reflect services and supports necessary to sustain the client's ability to live in their community. The Care Plan provides a focus for the needs identified in the functional assessments,

organizes the service delivery system to the client and helps to assure that the service being delivered is appropriate to the client's needs/problem.

The MSSP interdisciplinary care management team will develop a client-centered written comprehensive Care Plan for each client. It will be based on health and psychosocial assessment or reassessment findings, reflect all appropriate client needs, encompass both formal and informal services and will be written within two weeks of the latest assessment or reassessment.

The MSSP Care Plan includes:

- Statements of problems and needs determined upon assessment;
- Strategies to address the problems and needs; and
- Measurable goals or outcomes used to demonstrate resolution based upon the problem and need, the time frame, the resources available, and the desires and the motivation of the client and/or family.

References: MSSP Site Manual and MSSP Contract

Findings:

Four client records (#XXXXXXXXXXXXXXXXX) contained problem statements that did not fully describe why issues were problems for the clients.

Four client records (#XXXX, #XXXX, #XXXX, and #XXXXX) contained interventions in problem statements and/or goals.

Three client records contained information in assessments that identified client needs that were not included on care plans as follows:

- #XXXX – XXX XXXXX, and XXXXXXXXXX XXXXX;
- #XXXX –XXXXXXXXX XXXXXXXX;
- #XXXX – XXXXXXXX XXXXXX, XXXXXX XXXXXX, and XXXX.

The care plan in Client Record #XXXX contained a problem statement that was not client-centered in that it related to the XXXXXXXXX XXXXXXX.

Client Record #XXXX contained a problem regarding falls that was resolved due to the client not experiencing XXXX and the provision of XXXX. XXXXXX were ongoing issues for the client.

Client record #XXXX showed "XX" under "problem number" instead of separate problem numbers for issues number one and number three. The problems were similar.

Most goals on XXXXX care plans were not measurable. Conversely, most goals on 2009 care plans were measurable with the exception of Client Record #XXXX where ten of ten goals were not measurable.

Client Record #XXXX contained documentation that a XXXXX, XXXXX, and XXXXX were purchased for the client that were not on the care plan. Purchasing items not listed on care plans can result in recovery of funds.

Recommendations:

Incorporate the following TA into policies and procedures.

Technical Assistance:

Review MSSP Site Manual Section 3.640.3 Care Plan Components that states, "The sites may modify the care plan form (Appendix 22); however, the basic integrity and all components of the form must be maintained, and ample space given to each section to facilitate recording the required information. Whatever the format, the care plan document **will** include the following components:

A. Date
Enter the date that the problem/need was identified. Dating the problems will ensure that care plans are updated/revised when warranted by changes in the client's condition and goals (CMS Protocols, page 20).

B. Problem #
The "Problem #" section will list client problems in a sequential manner. The care plan problem numbers remain the same as long as the problem is active. Numbers will be added sequentially as additional problems are identified, including new problems identified during annual reassessments. Numbering problems facilitates identification of activities in developing and monitoring care plans (CMS Protocols, pages 20 and 23).

C. Problem Statement
1. This section of the care plan must contain descriptive problem statements. Problem statements are derived from areas of concern or problem areas identified in the reassessments for which specific services are provided and/or in which care management activities are initiated. **Note:** The medical diagnosis and the description of a client's function can be linked to describe a problem, but the diagnosis alone does not define the problem or substantiate the need for services; and a need by itself, without detail in the body of the assessment, does not substantiate a service purchase. Care plans must address specific needs identified for each client, rather than reflect an abbreviated, or "cookie cutter" process (CMS Protocols, page 19).

2. If there are problem areas identified that will not be addressed in the care plan, an explanation should be documented in the progress notes.

3. The problem areas identified for the care plan shall:

   a. Illustrate the need for care management,

b. Substantiate the need for service delivery, including informal, referred, and purchased services,

c. Clearly describe the circumstances within the client's informal and referred service resources that necessitate a purchase with waiver dollars.

d. Reflect the interdisciplinary team collaboration on assessment findings. During the care planning conference, problems not identified prior to the conference should be added.

D. Service Provider and Type
The Service Provider and Type section will list the service provider for all services (purchased and referred). The type of provider(s) for each service will also be entered:

I = Informal: a service provided without cost through the client's network of family, friends, or other informal helpers.

R = Referred: a service provided without cost through referral to a formal organized program or agency.

P = Purchased: a service purchased by MSSP through Waived Services funds.

C = Care Management: specific activities or interventions carried out by the care manager.

More than one provider type may be entered for an individual service.

E. Plan/Intervention
The Plan/Intervention section lists information pertinent to the problem and outlines possible actions, plans or solutions to solve the problem. Interventions that have the greatest probability of success are those that consider the client's preferences, perception of the problem or situation, and are compatible with the client's beliefs, values, and attitudes (CMS Protocols, pages 18, 20, and 23).

F. Goal/Outcome
This section will address client goals/outcomes for identified needs or problems; it should reflect the client's input and consider the client's preferences (CMS Protocols, pages 19, 20, and 23)."

Review MSSP Site Manual Section 3.640 Care Planning that states,

"The MSSP care plan includes:

- Measurable goals or outcomes used to demonstrate resolution based upon the problem/need, the time frame, the resources available, and the desires/motivation of the client/family."

Incorporate the following TA into policies and procedures.

When a new client need arises, evaluate the current problems on the care plan to determine whether proposed interventions could help address an existing problem. Every new intervention does not warrant its own problem. Similar issues can be combined into the same problem statement.

Suggested Problem Statements and Goals:

1. Problem Statement:
   - The client is at risk for XXXX due to history of experiencing XXXX per month and XXXX secondary to XXXX (XXXX).

   Goal:
   - The client will report no XXXX from XXXX over the next year.

   Interventions:
   - Purchase XXXX (XXXX)
   - Provide XXXX safety equipment–specify–XXXX (XXXX), XXXX, XXXX, XXXX
   - Obtain XXXX
   - Obtain XXXX (with XXXX)
   - Perform XXXX Assessment (XXXX)
   - Coordinate XXXX consult (XXXX)

2. Problem Statement:
   - The client is at risk for XXXX due to high level of need due to XXXX XXXX resulting in XXXX.

   Goal:
   - The client will experience XXXX during the next 12 months

   Interventions:
   - Provide XXXX for XXXX
   - Coordinate schedules for XXXX and other XXXX to visit client
   - Advocate for increased XXXX

3. Problem Statement:
   - The client is at risk for XXXX related to XXXX

Goal:

- The XXXX will report XXXX during the next 12 months.

Interventions:

- Coordinate XXXX (TAR)
- Purchase XXXX
- Purchase XXXX
- Purchase XXXX
- Coordinate XXXX

4. Problem Statement:
   - The client is at risk for XXXX due to inability XXXX secondary to XXXX and XXXX.

Goal:

- The client will maintain XXXX during the next 12 months.

Interventions:

- Provide XXXX for XXXX
- Obtain XXX (XXXX) (with prescription)
- Arrange XXXX/XXXX
- Coordinate XXXX (with prescription)
- Provide XXXX

Corrective Action:

The findings were diverse and the review team provided extensive TA to the site's management team during the review. A CAP is not required at this time.

CDA plans to conduct a follow-up review later this year to evaluate the site's progress toward improving care plans. CDA will determine whether a CAP is warranted at the time of this follow-up review.

Purchasing items for Client #XXXX that were not listed on the care plan was not a trend; therefore, CDA does not intend to pursue recovery of funds.

III. C Assessing and Documenting Client Risk

The goal of risk assessment is informed by the fact that MSSP clients have the right to refuse specific services and interventions. When a client refuses a service or intervention, the site must have a process of assuring that the risks associated with the refusal are addressed to the extent possible.

Assessing a client's ability to assume risk includes whether or not the client can:

- Make and communicate choices;
- Provide sensible reasons why choices were made;
- Understand the implications of choices; and
- Consider the consequences of choices.

A risk management plan will be developed when a situation arises where the client has chosen a course of action that may place the client at risk. This process allows for the systematic exploration of situations with a high possibility of an adverse outcome.

The status of the risk management plan must be monitored during regular monthly contacts by the CM. It must be formally reviewed or renewed at intervals mutually agreeable to the client and CM.

Reference: MSSP Site Manual

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

III. D. Progress Notes

Progress notes are the ongoing chronology of the client's events and care management. They must address: health and safety issues; the provision of services as planned; whether services continue to be necessary and appropriate; whether they are being delivered as anticipated; and the client's response to the service. Notes shall include the following, as appropriate:

- The date and type of MSSP staff contact with the client;

- A record of all events that affect the client and the status or validity of the Care Plan;
- Actions taken when there are discrepancies between the Care Plan and services delivered;
- Any education or counseling support provided to either the client or caregiver;
- Evaluative subjective and/or objective comments on all services delivered and client outcomes in relation to needed services; and
- A reflection of the relationship between identified problems and services delivered or not delivered.

Progress notes must include any significant information regarding the client's relationship with family, community or any other information which would impact the established goals for the client's independent living.

Reference: MSSP Site Manual

Findings:

Three client records (#XXXX, #XXXX, and #XXXX) contained progress notes that did not address all care plan problems.

Nine client records (#XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, #XXXX, and #XXXX) contained progress notes that did not address all care plan problems during the month of reassessment.

Recommendations:

Conduct a training session within 60 days of the date of this report to ensure all CMs understand requirements for documenting the status of all care plan problems and all care management activity during months of reassessment. Submit to CDA the name of instructor, training materials used, and a list of attendees.

Incorporate the following TA into policies and procedures.

Technical Assistance:

Review MSSP Site Manual Section 3.820 What Progress Notes Include that states, "Progress notes are the ongoing chronology of the client's events and care management. They **must** address: health and safety issues; the provision of services as planned; whether services continue to be necessary and appropriate; whether they are being delivered as anticipated; and the client's response to the service (see also above, Section 3.640.6, Care Plan Monitoring). Notes shall include the following, as appropriate:

- Progress notes must address and document each problem listed in the care plan."

Corrective Action:

The number of findings constituted a trend; therefore, a CAP is required.

III. E. Case Record

MSSP sites must maintain up-to-date, centralized, confidential and secured case file records for each MSSP client, utilizing mandatory CDA forms. Sites are to implement case documentation, date and signature requirements, revisions and corrections according to the MSSP Site Manual specifications and time frames.

Case record documentation is a tangible part of the care management process which must be clear, timely, accurate, legible, appropriate and complete, providing the CM with working documents that are effective and efficient. The site shall also maintain and make available records for inspection and audit by the State.

Reference: MSSP Site Manual

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

IV. AUTHORIZATION AND UTILIZATION OF SERVICES

MSSP sites are responsible for maintaining complete records for funds received under the MSSP contract, including the tracking for purchased and referred services. Sites are required to cooperate with the State in the monitoring, assessment and evaluation of site processes. Sites must provide the CDA any relevant information requested through ad hoc reports that are related to administrative procedures.

The Department's Audit Branch will review the reconciliation process between service authorization and disbursement of payments to ascertain whether services authorized and provided were:

- Consistent with the Care Plan,
- Verified by the site, and
- Differences between authorized and verified services noted.

CDA MSSP staff will review selected client records to verify that correct procedures were followed in authorizing services for clients.

In authorizing services for a client, the CM will use the following prescribed order of priorities:

1. All services available through the informal support of family, friends, etc., must be used.

2. Existing Title XVIII Medicare, Title XIX Medi-Cal, Title XX Social Services, Title III Older Americans Acts, the Special Circumstances Program, and other publicly-funded services for which the client is eligible, and which are available in the community, must be relied upon, coordinated and recorded in developing a Care Plan. Within MSSP these services are called "Referred" services.

3. Only after the client's informal support and the existing public and private services are reviewed and optimally used, can the CM request the use of MSSP funds to purchase Waived Services. Within MSSP, these services are also called "Purchased" services.

CMs must be aware of the cost associated with maintaining a client in MSSP. When considering the acquisition of a piece of client equipment, e.g., emergency response device or non-medical home equipment, it is important to analyze both the purchase and rental options to determine the most cost-effective approach.

References: MSSP Site Manual and Contract

IV. A. Service Planning and Utilization Summary

The SPUS is an element of the client's Care Plan. The SPUS sets forth specific service information: who is the provider, what service is provided, how much it will cost, and what is the source of payment.

The SPUS is to be completed for each client for each month they are enrolled in the program. The services tracked on the SPUS are those purchased with waived services funds and certain categories of services obtained by referral to other funding sources.

The primary CM signs each client's verified SPUS each month. If the client's tracked costs are more than 95%, but less than 120%, of the site's benchmark, the Supervising CM must also sign; if costs exceed 120%, the Site Director must sign the SPUS, too.

References: MSSP Site Manual and Contract

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

IV. B. Tracking Cost Effectiveness

In addition to care management services provided by the MSSP site staff, the program is authorized to purchase supportive services from the list of approved Waived Services.

MSSP CMs are required to follow service authorization procedures which maximize the use of the informal support system and existing community service delivery systems (including use of the Medi-Cal Treatment Authorization Request [TAR] process) prior to the use of Waived Services.

References: MSSP Site Manual and Contract

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

IV. C. Vendor Agreement Review

Sites are responsible for arranging for the provision of client services. In addition to the MSSP Site Manual, there are two documents that must be consulted in this regard: the current MSSP Waiver and the individual site contract with CDA. Both the Waiver and the contract set forth policy and procedures which must be followed in structuring the terms and conditions of agreements with local service providers. In the contract, the site agrees to directly provide or arrange for the continuous availability and accessibility of all services identified in each client's care plan. In addition, the site agrees to maintain sufficient written vendor agreements for the following minimum array of Waived Services at all times.

(a) Adult Day Support Center (ADSC) and Adult Day Care (ADC)
(b) Housing Assistance
(c) Domestic Chore and Personal Care Services
(d) Care Management
(e) Respite Care
(f) Transportation
(g) Meal Services
(h) Protective Services
(i) Special Communications

Sites are required to maintain specific information and documents on each vendor of services. Sites must maintain copies of current license and insurance documents, and establish a tickler file or other system to ensure timely updating of this information. The Vendor Record Review Tool can assist sites with maintaining service provider compliance to MSSP requirements.

References: MSSP Site Manual and Contract

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

V. QUALITY ASSURANCE ACTIVITIES

Quality assurance (QA) is characterized by a focus on systems, processes and outcomes, rewarding excellence, and working in a collaborative or partnership environment. It is ongoing, with each element continuously informing and supporting the entire process. Rather than replacing traditional program evaluation activities, quality assurance builds on and integrates them into an organized system.

MSSP sites are required to deliver quality services to clients through the continual demonstration of best practices in clinical care management. Sites will have a written policy describing their QA activities that includes a vision/mission statement, which ensures that staff fully support the mission and specifies the elements employed to secure this vision. QA elements include, but are not restricted to, a process of peer/internal review and a means to solicit client satisfaction with MSSP services.

V. A. Peer/Internal Review

Peer/Internal Review activities focus awareness on care management activities practiced within the program. Driven by the needs and abilities of the care management staff, this review process offers CMs an opportunity to learn from each other through the critical examination of professional practices.

References: MSSP Site Manual and MSSP Contract

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

V. B. Client Satisfaction

Client Satisfaction Surveys, or other methods of obtaining information regarding client satisfaction, are instrumental to program operation analysis and the provision of quality client services.

References: MSSP Site Manual and MSSP Contract

Findings:

There were no findings in this area.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

V. C. Home Visit

A home visit to a client ensures that clients are informed of their rights and receive quality services that meet their needs.

References: MSSP Site Manual and MSSP Contract

Home Visit Summary:

A CDA Nurse Evaluator and a site SWCM made a home visit to Client #XXXX on XXXX, XXXX, XXXX. The client was a XX year old XXXX of XXXX, XXXX and XXXX XXXX descent. The client lives with XXX X and XXXX and XXX X provides the majority of care for XXXX. All were present during the visit.

The client's medical history includes XXXX, XXXX XXXX XXXX with XXXX XXXX, XXXX, XXXX, XXXX, XXXX XXXX and XXXX. XXX also has a history of XXXX and XXXX to XXXX and XXXX XXXX.

The SWCM reviewed the care plan with the client and obtained an update of current medications. No new needs were identified. The SWCM agreed to follow-up on some problems the client was having with XXXX XXXX XXXX. There was also a discussion regarding XXXX the client XXXX XXXX and XXXX. The SWCM praised the client for XXXX. The client was not wearing XXXX, but reported XXX always XXXX. The client stated XXX is XXXXX with how XXX is treated by XXX CM.

The client stated XXX was aware of XXX rights as a participant in the program. XXX feels this program allows XXX to live where XXX wants to live. XXX could not think of anything that would make the program better.

Recommendations:

Continue with current policies and procedures.

Corrective Action:

A CAP is not required.

VI. BEST PRACTICES

Best Practices are those processes, policies, procedures and methods of casework that demonstrate exemplary work in the field of care management. Examples of Best Practices include, but are not limited to, administrative processes, the work done within an individual case, and general practices developed and applied to the work of all site care management staff.

The review team would like to acknowledge the site for the following examples of Best Practices:

1. The site uses extra assessment tools to detect abuse and determine pain levels for all clients.

2. The site uses a "Protocol Screening Tool" to collect information from all clients regarding medications, falls, and incontinence in order to address these issues.

3. The site conducts peer reviews and client satisfaction surveys quarterly.

VII. SUMMARY

The site is acknowledged for its hospitality and for being receptive to the recommendations made and the TA provided during the UR process. This review team is available to provide continued technical support regarding the findings identified in this report.